



MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____ Time _____ (scheduled) Study Number(s) _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____ Male ☐ Female ☐
month day year

Body Part to be examined _____ Referring Physician _____

Tech Notes: _____

Contrast _____

Have you ever had any surgery or procedure on the part of the body we're scanning today? ☐ No ☐ Yes
If yes, please indicate the date and type of surgery: _____

Have you ever had any other surgery or procedure that left any implanted metallic or electronic devices? ☐ No ☐ Yes
If yes, please indicate the date and type of surgery: _____

Have you ever had an MRI before? If yes, body part? _____ ☐ No ☐ Yes
If yes, location and date? (month/year) _____

Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
If yes, please describe: _____

Have you had any other diagnostic imaging studies on the part of the body we're scanning today? ☐ No ☐ Yes

X-ray	When _____	Where _____
CAT Scan (CT)	When _____	Where _____
Bone Scan	When _____	Where _____

Have you had an injury to the eye involving metallic objects/fragments (metallic slivers, shavings, etc.)? ☐ No ☐ Yes
If yes, please describe: _____

Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
If yes, please describe: _____

Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
If yes, please list: _____

Are you allergic to any medication? ☐ No ☐ Yes
If yes, please list: _____

Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes

Do you have any renal (kidney) disease, reduced renal function or renal failure? ☐ No ☐ Yes

Do you have any known personal history of Cancer? ☐ No ☐ Yes
If yes, please list: _____

Have you ever undergone chemo- or radiation therapy? ☐ No ☐ Yes
If yes, when & what body part (radiation): _____

Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures? ☐ No ☐ Yes
If yes, please describe: _____

Are you currently a smoker or have you smoked regularly in the past? ☐ No ☐ Yes
If yes, how many packs per day _____ and for how long _____

For female patients:

Date of last menstrual period: ____/____/____ Postmenopausal? ☐ No ☐ Yes

Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes

Are you currently breastfeeding? ☐ No ☐ Yes

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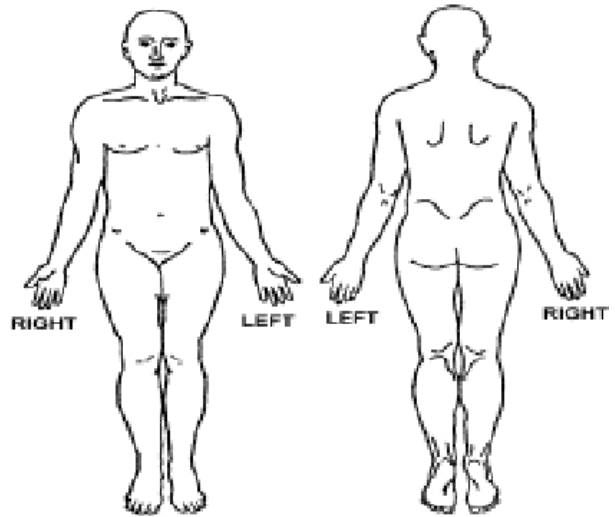


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- | | | |
|--|-----------------------------|------------------------------|
| Aneurysm clip(s) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cardiac pacemaker | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Any other electronic implant or device | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Magnetically-activated implant or device | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Neurostimulation system | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Spinal cord stimulator | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Internal electrodes or wires | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bone growth/bone fusion stimulator | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cochlear, otologic, or other ear implant | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Insulin or other infusion pump | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Implanted drug infusion device | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart valve prosthesis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eyelid spring or wire | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Artificial or prosthetic limb | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Metallic stent, filter, or coil | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Shunt (spinal or intraventricular) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Vascular access port and/or catheter | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Radiation seeds or implants | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Swan-Ganz or thermodilution catheter | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Medication patch (Nicotine, Nitroglycerine) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Any metallic fragment or foreign body | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Wire mesh implant | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tissue expander (e.g., breast) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Surgical staples, clips, or metallic sutures | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Where: _____ | | |
| Joint replacement (hip, knee, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bone/joint pin, screw, nail, wire, plate, etc. | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| IUD, diaphragm, or pessary | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Dentures or partial plates | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tattoo or permanent makeup | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Body piercing jewelry | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hearing aid (<i>Remove before entering MRI room</i>) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other implant _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Breathing problem or motion disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Claustrophobia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Please mark on the figure(s) below the location of any area of pain related to the exam you are having today



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

NOTE: Notify MR staff immediately if "YES" to any of the above.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____ / ____ / ____
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

☐ MRI Technologist ☐ MRI Tech Assistant ☐ Radiologist ☐ Other _____